District of Columbia State Innovation Model
Care Delivery Work Group: Meeting Summary

November 23, 2015
3:00 p.m. – 4:30 p.m.

Participants present: Lisa Fitzpatrick, Shelly Ten Napel, Joe Weissfeld, Mark Weissman, Emily Eelman, Edwin Chapman, Victor Freeman, Sarah Rogue, Judith Hinton, Peter Tuths, Ana Veria, Richard Katz, Lisa Millstone, Carmen Hernandez, Leslie Lyles Smith, Lavdena Orr, Robert Howard, Marie Dorelus, Lisa Alexander, Gurusuer Panjrath, Dena Hasan, Ellie Beclc, An-Tsun Huang, Colleen Sonosky, Kandis Driscoll, Wes Rivers, C. Hoston, Lara Pukatch, Suzanne Fenzel, Cyd Campbell, Chris Botts

TOPIC	DISCUSSION
Initial DHCF Considerations for Health Home 2	• **Joe Weissfeld presented DHCF's initial considerations for Health Home 2. Stakeholders had the following reactions**: ➢ *Eligibility*: Enrolling beneficiaries into Health Home 2 simply based on the chronic condition groupers presented may not adequately target high-cost, high-need patients. As a result, tiering mechanisms (e.g. past cost, past utilization, risk scores, etc) will be critical in identifying the right patient population for health home 2. o Using chronic homelessness as an eligibility criterion raises concern about the potential for high no-show rates; however, the group generally supported the need for enhanced care coordination for the group. o Generally, those who are chronically homeless have a chronic condition; defining the status as either a condition or risk factor will help to clarify the eligibility criteria. ➢ *Proposed Principles for Eligibility Criteria*: There is a desire to structure eligibility criteria in a manner that heavily targets FFS beneficiaries (who could benefit greatly from care coordination) while also including MCO members. It would be helpful to compare quality and

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	health outcomes data for FFS beneficiaries to MCO members to better understand group differences in care coordination. o Some participants pointed out that enhanced care coordination efforts are most effective when delivered by a provider and not an MCO and encouraged that MCO remain eligible for Health Home 2. ➢ *Potential Chronic Conditions for Health Home 2*: Some chronic conditions have a tendency to naturally cluster together and only present themselves as one chronic condition. DHCF should consider utilizing more sophisticated targeting mechanisms that highlights when "clustering" is happening. ➢ *Possible Tiering Criteria*: Participants suggested using multiple analytic tools to tier patients, including those that consider past utilization and risk stratification/prediction. Some tools use benchmarks to determine if a patient is "high-cost" given his/her condition, health seeking behavior, etc. o To determine high-cost, high-need patients, MCOs uses predictive analytic tools that assess ED visits, pharmacy utilization, housing status, etc. ➢ *Opt-In vs. Opt-Out*: The opt-out model is concerning for some providers because they may not be the primary care giver of the patients they are assigned, especially when considering that this population bounces around frequently. As a result, it is difficult for a provider to be accountable for a patient that he/she rarely sees. o What has been the impact of the opt-in vs. opt-out model on patients in different region?
Health Home Staffing Models	• **Stakeholders discussed possible staffing models to consider in the health home; suggestions include:** ➢ Soliciting entities that have a strong track record of training case managers, community health workers, navigators, etc.

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	➢ Tying payment to quality metrics and accountability ➢ Developing a resource bank so that small practice providers have the ability to refer patients to outside services when necessary without acquiring an additional administrative burden. ➢ Suggestions to look at Seattle's FEMS initiative and Buffalo's Health Home initiative